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CAHIP STATE PRESIDENT'S MESSAGE

Grow with CAHIP

A message from Craig Gussin, President of CA Agents & Health Insurance Professionals (CAHIP)

Hello CAHIP OC Members,

As I begin my year as your CAHIP President, my theme is Grow with CAHIP.

CAHIP wants to start by thanking the CAHIP OC board for all the great events they put on all year long, and we want to thank you, the member, for supporting your chapter.

As we begin our new board year for both the CAHIP State and for the CAHIP OC chapter, please know that CAHIP is here to help & support CAHIP OC and you, the agent.

We at CAHIP want to help you grow as a chapter and help you, the agent, grow too.

We will do this by providing virtual and in-person meetings geared towards Group, IFP and Medicare.

CAHIP has heard agents across the State ask for more Group and IFP educational meetings and we will be providing that to you.

The CAHIP Innovate meeting on February 3rd, 2027, at the Riverside Convention Center will be designed to do just that.

There are some big changes happening in Covered California in 2027 and 2028.

As we know more, so will you.

Again, thank you for being a CAHIP member

Craig Gussin
President of CA Agents & Health Insurance Professionals (CAHIP)

LEGISLATIVE RESOURCES

California – CAHIP | CAHIP – Legislative Resources
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President's Message

Sarah Knapp

CAHIP OC Chapter President

I hope you all had a wonderful and relaxing summer and are feeling refreshed and ready to take on the fourth quarter!

As we head into one of the busiest seasons of the year, CAHIP OC remains committed to supporting our members with valuable opportunities to stay informed, engaged, and connected.

This fall, we are excited to offer a variety of educational and networking opportunities. In October, we invite you to join us for our Legislative Update featuring our California lobbyist, Faith Borges. This important meeting will provide valuable insight into current legislative and policy developments impacting our industry and the clients and communities we serve.

We will also continue to bring you a mix of engaging webinars and in-person gatherings in the coming months. These events reflect our ongoing commitment to delivering value to our members through education, advocacy, and meaningful networking opportunities.

As always, we are here for you. Your feedback, ideas, and involvement help make CAHIP OC stronger, and we encourage you to share your suggestions and stay connected.

Wishing you all a strong, successful, and productive fourth quarter!



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The Healthcare Cost Collision

Why California carriers, hospitals, employers and employees are all feeling the squeeze

Prepared for COIN / CAHIP Insurance Magazine

By Anne Kelly

Thesis: California is trying to slow healthcare spending growth to 3.5% in 2025-2026 and 3.2% in 2027, while hospitals seek higher commercial reimbursement, carriers absorb pharmacy and utilization trend, federal coverage subsidies are shifting, and employers are receiving renewals that feel disconnected from the state affordability target.

At first glance, the 2026-2027 renewal cycle can look like another painful year of medical inflation. But the more carefully one looks, the more it appears that multiple pressure systems are colliding at once. The collision is especially visible in California, where the Office of Health Care Affordability (OHCA) has begun putting a public benchmark around what used to happen mostly behind closed doors: how fast healthcare spending should be allowed to grow.

This article argues that the current market friction is not simply a carrier-pricing story or a hospital-pricing story. It is a deeper affordability crisis in which provider reimbursement, pharmacy inflation, chronic disease, public-payer pressures, Covered California subsidy changes, Medi-Cal eligibility changes, and employer risk-pool dynamics are converging. The result is a market in which hospitals and carriers are increasingly “at each other’s throats” when contracts come up for renewal, while employers continue to receive Q4 2026 and Q1 2027 renewal increases that often exceed the state’s cost-growth target by a wide margin.

1. The OHCA benchmark: a new public yardstick

OHCA’s statewide spending target begins at 3.5% for performance years 2025 and 2026, drops to 3.2% for 2027 and 2028, and reaches 3.0% in 2029. The target is not a premium cap. It is a per-capita health spending growth target intended to signal that healthcare spending should not continue to grow faster than California household income.¹

That distinction matters. Employers buy premiums, not abstract medical trend. A carrier renewal can be driven by more than provider reimbursement: pharmacy costs, utilization, risk adjustment, population morbidity, reserves, administrative costs, benefit mix and product-specific experience all play a role. Still, the OHCA target changes the conversation. It creates a public affordability benchmark against which carriers, hospitals and large physician organizations can increasingly be judged.

Performance year
OHCA statewide target
Why it matters

2025 3.5%
First target year; public reporting begins.

2026 3.5%
Target remains at 3.5%; enforcement begins with 2026 performance.

2027 3.2%
Target tightens just as 2027 renewals and federal coverage changes hit the market.

2029 3.0%
Long-term affordability endpoint.

2. The baseline: carriers were already above the target

OHCA’s Baseline Report: Health Care Spending Trends in California, 2022-2023 established the pre-target landscape. Among major commercial carriers, medical expense growth was already generally above the later 2025 target. In simplified terms, the market was operating around 4% to 6.5% commercial total medical expense growth before the 3.5% target took effect.²



This does not mean those carriers “failed” OHCA in 2023. The target had not yet taken effect. It does mean California is asking the market to slow a trend that was already running meaningfully above the target before the measurement era began.

Carrier	Hospital / provider system	Period	Publicly identified issue
Blue Shield of CA	Providence	2023-2024	Providence issued a termination notice in Oct. 2023; more than 110,000 members faced possible out-of-network status June 1, 2024. Blue Shield said the requested rates were not sustainably affordable; agreement followed in May 2024.
Blue Shield of CA	Stanford Medicine	2024	After extensive negotiations, a new agreement became effective Sept. 1, 2024 for commercial HMO/PPO. Some Individual/Family Plan and Covered California Stanford access remained out of network.
Anthem Blue Cross	Providence	2024 -> 2025	Providence said it sought fair and sustainable reimbursement rates; a Jan. 1, 2025 disruption was avoided when the parties reached agreement in Dec. 2024.
Anthem Blue Cross	Sutter Health	2024 -> 2025	A Jan. 1, 2025 network termination was threatened during negotiations; the parties reached terms and later announced a multi-year agreement.
Anthem Blue Cross	Stanford Medicine	2025	A Sept. 1, 2025 termination was threatened. A multi-year agreement was reached Aug. 25, preserving HMO, EPO and PPO access.
Blue Shield of CA	UC Health / UCSF	2025	UC Health threatened termination while seeking higher reimbursement. Negotiations were extended and an agreement was reached in July 2025.
Blue Shield of CA	Hoag	2025	A June/July 2025 commercial termination was possible during negotiations. Blue Shield publicly cited affordability and Hoag facility costs; a new agreement preserved commercial access.
Blue Shield of CA	Sutter Health	2025	A major statewide renewal was completed early, before year-end expiration. It is included as a contrast: a large negotiation that did not escalate into the same public standoff.

3. Why hospitals and carriers are fighting harder

The hospital-carrier conflict is driven by a simple arithmetic problem. Hospitals argue that labor, nurses, physicians, drugs, supplies, technology, capital costs, seismic and regulatory compliance, and public-payer reimbursement pressure are all rising. Carriers argue that they cannot accept provider price demands that would push employer premiums and consumer costs even higher, particularly while the state is measuring the system against a 3.5% or 3.2% target.

The contract table is where those pressures collide. If a hospital system seeks a large commercial reimbursement increase, a carrier has only a few options: accept the increase and eventually reflect it in premiums; reject the increase and risk network disruption; or accept part of it and try to recover savings elsewhere through utilization management, narrow or high-performance networks, prior authorization, site-of-care management, pharmacy management or value-based contracting.

4. Public California contract disputes show the pressure

The current contract friction did not suddenly appear with the 2025 OHCA target. Public negotiations were already escalating in 2023 and 2024, then continued across a wider group of major California systems in 2025 and 2026. The timeline below is not an exhaustive census of every confidential negotiation; it highlights well-documented disputes and threatened network terminations that show the trend.

Blue Shield of CA Stanford Medicine 2024 After extensive negotiations, a new agreement became effective Sept. 1, 2024 for commercial HMO/PPO. Some Individual/Family Plan and Covered California Stanford access remained out of network.

Anthem Blue Cross Providence 2024 -> 2025 Providence said it sought fair and sustainable reimbursement rates; a Jan. 1, 2025 disruption was avoided when the parties reached agreement in Dec. 2024. Anthem Blue Cross Sutter Health 2024 -> 2025 A Jan. 1, 2025 network termination was threatened during negotiations; the parties reached terms and later announced a multi-year agreement. Anthem Blue Cross Stanford Medicine 2025 A Sept. 1, 2025 termination was threatened. A multi-year agreement was reached Aug. 25, preserving HMO, EPO and PPO access.

Blue Shield of CA UC Health / UCSF 2025 UC Health threatened termination while seeking higher reimbursement. Negotiations were extended and an agreement was reached in July 2025. Blue Shield of CA Hoag 2025 A June/July 2025 commercial termination was possible during negotiations. Blue Shield publicly cited affordability and Hoag facility costs; a new agreement preserved commercial access.

Blue Shield of CA Sutter Health 2025 A major statewide renewal was completed early, before year-end expiration. It is included as a contrast: a large negotiation that did not escalate into the same public standoff.

Blue Shield of CA Community Medical Centers / CHP 2026 The system went out of network Feb. 1, 2026 after negotiations failed. Blue Shield cited unreasonable rate demands and warned of premium effects on Covered California, CalPERS and employer plans.

Anthem Blue Cross Scripps Health 2026 A major 2026 negotiation carried an Oct. 1 termination risk. Anthem publicly said Scripps sought 15%-20% annual price increases.

Blue Shield of CA Providence 2026 A new statewide agreement announced July 31, 2026 maintained commercial HMO/PPO and Medi-Cal access across Providence hospitals and physician organizations.

The trend is the important point. The 2023-2024 Providence-Blue Shield confrontation predates OHCA enforcement, so OHCA cannot fairly be described as the cause of these disputes. But by 2025-2026, multiple large California systems were simultaneously pressing Anthem and Blue Shield over reimbursement and network terms just as the state began measuring spending growth against 3.5% targets. The Scripps-Anthem dispute makes the arithmetic particularly visible: a publicly alleged 15%-20% annual provider price request is not directly comparable with OHCA total expenditure growth, but it demonstrates the gap carriers may be trying to reconcile at the negotiating table.

Timeline sources: Blue Shield of California and Providence (2024, 2026); Providence and Anthem (2024); Blue Shield and Stanford Medicine (2024); Stanford Medicine and Anthem (2025); Blue Shield and UC Health, Hoag and Sutter (2025); Blue Shield and Community Medical Centers (2026); Anthem and Scripps (2026).

5. Kaiser's vertical model: not immune, but structurally different

Kaiser Permanente is not exempt from cost pressures. It faces labor, drug, technology and utilization pressures like every other healthcare organization. But its model is structurally different. Kaiser describes itself as combining health coverage and care delivery into one coordinated experience, with the health plan financing care delivered through Permanente physicians, hospitals and medical facilities. It also describes its physicians as salaried and the model as aligning incentives around coordinated care rather than volume.⁷

That difference matters. A traditional carrier must negotiate rates with independent hospital systems and physician groups for access to its network. Kaiser's core delivery system is more vertically integrated. That does not automatically make Kaiser cheaper in every market or every product, but it may help explain why Kaiser often appears to have somewhat lower trend in certain public comparisons. The larger point is that cost containment may increasingly depend not only on negotiated discounts, but on care model design.

6. Q4 2026 and Q1 2027 renewals: what is weighing on small and large group

For Q4 2026 and Q1 2027, brokers should be prepared to explain that renewal increases are not being driven by one factor. They are being driven by a stack of pressures.

Pressure	Small group impact	Large group impact
Hospital/provider reimbursement	Directly affects fully insured rates; smaller employers have less negotiating leverage.	Large employers can use plan design, network strategy and purchasing leverage, but still face hospital system pricing.
Pharmacy and specialty drugs	High-cost claims can materially affect community-rated or pooled med; GLP-1 and specialty utilization is a visible concern.	Large employers increasingly scrutinize GLP-1 coverage, specialty management, PBM terms and formulary strategy.
Utilization and acuity	Sick pool populations drive higher rates; preventive gaps can become claims.	Large employers see chronic disease and high-cost claims in experience reporting.
Level-funded migration	Healthier small groups may leave fully insured pools, worsening morbidity for those who remain.	Less direct; many large employers are already self-funded.
Federal coverage changes	Covered CA subsidy loss and Medi-Cal churn can shift employee decisions and potentially payer mix.	Employers with hourly or lower-wage populations may see more enrollment pressure or coverage gaps.
OHCA pressure	Not a premium cap; may intensify carrier-provider contracting friction.	May increase transparency and pressure around hospitals, carriers and provider organizations.

National small-group filings show the same pattern. KFF's review of 2027 filings found a median proposed small-group premium increase of about 14%, with insurers citing rising medical prices and utilization, high-cost specialty drugs, GLP-1 utilization, behavioral health utilization, declining enrollment and worsening risk-pool morbidity; some filings specifically attribute the worsening fully insured risk pool to the rise of level-funded arrangements among healthier small employers.⁸

Aon's 2027 employer forecast points in the same direction for the broader employer market: U.S. employer healthcare costs are projected to rise 9.5%, with utilization, chronic conditions, high-cost claims, specialty medications, GLP-1 therapies and even provider coding/documentation technology contributing to cost pressure.⁹

7. Covered California and Medi-Cal changes add another layer

The individual market and public coverage changes are not the same thing as employer renewal trend, but they are part of the same healthcare financing ecosystem. Covered California announced a preliminary weighted average rate increase of 9.9% for 2027, with Anthem at 13.0%, Blue Shield at 12.5%, Health Net at 13.2%, Kaiser at 6.7%, and the overall marketplace at 9.9%. Covered California attributed the increase to rising healthcare costs, pharmacy expenditures, broader industry challenges, and federal actions including the failure to extend enhanced federal tax credits.¹⁰

Covered California had already reported the impact of the subsidy change in 2026: new enrollment was down 32%, middle-income renewals that lost all enhanced premium tax credits had a 22% cancellation rate, and more than 130,000 renewing Californians switched to Bronze plans.¹¹

At the same time, DHCS states that H.R. 1 Medi-Cal changes are expected to affect up to two million Medi-Cal members. Beginning January 1, 2027, certain expansion adults face work or community-engagement rules unless exempt, and some members must renew Medi-Cal every six months rather than annually.¹²

These changes may affect employer markets indirectly. Some lower-wage employees who lose or churn off Medi-Cal may look to employer coverage. Others may remain uninsured. Hospitals may experience payer-mix pressure and uncompensated-care concerns, while carriers and employers may see enrollment behavior change. These are emerging risks rather than fully proven causes of current employer premium increases, but they are important to watch.

8. The underbelly: chronic disease and the American diet

The financing conversation can miss the deeper utilization question: why are so many Americans consuming so much healthcare in the first place? CDC states that 90% of the nation's \$5.3 trillion in annual healthcare expenditures are for people with chronic and mental health conditions.¹³ That means any serious affordability conversation must include chronic disease, not merely unit prices.

The post-World War II and especially post-1970 food environment changed dramatically. USDA data show that between 1970 and 2003, food available for consumption increased 16%, calories increased by 523 calories per person per day, added fats and oils rose 63%, grain consumption rose 43%, sugars and sweeteners rose 19%, and corn sweetener consumption increased 400%.¹⁴ A later USDA review noted that about two-thirds of U.S. adults were overweight or obese in 2003-2004 compared with 47% in 1976-1980, and that the adult obesity rate more than doubled from 15% to 32%.¹⁵

It would be too simple to say the American diet is the only cause of the healthcare cost crisis. Aging, smoking history, inactivity, alcohol use, environmental exposure, socioeconomic conditions, administrative complexity, medical prices, provider consolidation, technology and drug innovation all matter. But it is reasonable to argue that population health is the upstream cost driver that makes every downstream financing problem harder.

9. The broker's message: premium is the symptom, disease burden is the cause

For employers, the renewal conversation often begins and ends with the percentage increase. But brokers can add value by explaining the chain underneath the number:

Poor population health and chronic disease -> higher utilization -> higher medical and pharmacy claims -> hospital revenue pressure and carrier claims pressure -> more contentious provider negotiations -> higher employer premiums and employee cost sharing.

If the market only negotiates lower prices after people are already chronically ill, it may slow trend but it will not cure the affordability problem. Long-term healthcare cost containment must include primary care, nutrition, metabolic health, obesity prevention, diabetes reversal and prevention, behavioral health, musculoskeletal health, medication adherence, early cancer detection and better site-of-care decisions.

Conclusion: California is entering a healthcare affordability stress test

OHCA did not create the healthcare cost problem. Hospital consolidation, drug costs, chronic disease, utilization, public-payer shortfalls, employer risk-pool erosion and administrative complexity were already present. But OHCA may be forcing the conflict into the open by placing a public target on spending growth at the same time carriers, hospitals, employers and consumers are all under stress.

The question for California is not simply whether the state can impose a 3% cost-growth trajectory. The question is whether the healthcare system can change enough to live within that trajectory. That requires more than rate negotiation. It requires care-model redesign, pharmacy strategy, primary-care investment, administrative simplification, better use of technology, and a far more serious commitment to improving the metabolic and chronic-disease profile of the population.

For brokers and consultants, this is the story behind the renewal: premiums are the visible number, but the battle underneath is over who absorbs healthcare inflation that remains far above the affordability target. The broker who can explain that larger system collision will be better equipped to guide employers through the difficult 2026-2027 renewal cycle.

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About the Author

Anne T. Kelly Anne T. Kelly is President of Kelly & Kelly Insurance Services/Patrick & Patrick Insurance Services. Her formal education as a Cost Accountant gives her a distinctive framework for interpreting the financial and compliance implications of employee benefits, including the Affordable Care Act's Employer Shared Responsibility rules. She has more than 25 years of experience in the sales and administration of employee benefit programs, with particular expertise in eligibility, employer reporting and ACA compliance. Anne is a frequent speaker and educator for CAHIP and ADOMA, presenting on topics including Healthcare Affordability and the forces driving medical premiums; the Affordable Care Act and employer reporting requirements; tax write-offs and the tax treatment of benefits through payroll versus individual tax returns; and California Pay Transparency requirements. She is also an approved California Department of Insurance instructor on Disability Insurance and Section 125 plans, as well as Healthcare Cost crisis and has spoken to insurance-industry and employer groups throughout California.



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The Inland Empire, Orange County, and San Diego chapters came together to support agents serving the Healthcare market.

The 14th Annual Senior Summit was a great success in its new home at the Riverside Convention Center. Led by Senior Summit Co-Chairs Maggie Stedt (OC), Ricky Haisha (SD), and Yolanda Web (IE), the three-day event brought together agents, sponsors, exhibitors, volunteers, and chapter leaders from across Southern California.

544

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16

new member applications
received by the end of the
conference

9 IE • 4 OC • 3 SD

new applications by chapter

Legislative updates, carrier changes, and education

Legislative updates and carrier plan changes led the Summit, helping agents prepare for Medicare market shifts. Continuing education and practical sessions on cross-selling, AI, cybersecurity, compliance, technology, and Medicare supported that focus. NFL quarterback Vince Ferragamo appeared briefly as a keynote on team building, planning, attitude, and teamwork. Steve Sax appeared at the Alignment booth.

A shared effort

The event's success was made possible by the dedication of volunteers, speakers, sponsors, exhibitors, and the Senior Summit Executive Committee. Special thanks to the many chapter and industry partners who supported the program, education, meals, refreshments, registration, and attendee experience.

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SENIOR SUMMIT 2026: A POWERFUL SO-CAL COLLABORATION

The Inland Empire, Orange County, and San Diego chapters came together to support agents serving the Healthcare market.



"If You Know, You Know" – Join the Momentum

One of the distinct privileges I have as a member of CAHIP Orange County is the opportunity to travel to both Washington, D.C. and Sacramento to meet directly with legislators and their staff to discuss the vital role that agents and brokers play within the health insurance industry.

Each year, we have the opportunity to share real-world stories about the challenges our clients face and the important work we do to help individuals, families, seniors, and employers navigate an increasingly complex healthcare system. While these conversations are always valuable, one thing that continues to surprise me is how many of the legislative staff members we meet with are in their mid-to-late twenties and have never personally experienced many of the healthcare challenges that consumers face.

In many cases, they have encountered frustrations themselves such as difficulty finding a provider, confusion over benefits, unexpected medical bills, or challenges accessing care, but they have never connected those experiences to the policies and legislation being discussed. They often do not realize how seemingly small regulatory changes can have significant consequences for healthcare access, affordability, and consumer support.

These conversations serve as an important reminder of why advocacy matters.

As agents and brokers, we are on the front lines every day. We see firsthand how legislation affects consumers, employers, healthcare providers, and insurance carriers. We understand the real-life impact of policy decisions because we help people navigate those impacts every day.

Without our voice, lawmakers are often left making decisions based solely on data, reports, and theoretical outcomes. Through CAHIP and NABIP, we have the opportunity to provide something equally important: real-world perspective.

Whether we are advocating for consumer access to licensed agents, protecting employer-sponsored healthcare, preserving compensation structures that allow agents to continue serving their clients, or improving access to affordable coverage, our collective voice helps policymakers understand how their decisions affect the people they represent.

This is also why your membership in CAHIP Orange County is so important.

Every member strengthens our ability to advocate effectively. Membership provides the resources, relationships, and credibility needed to maintain a presence in Sacramento and Washington, D.C., where critical decisions affecting our profession and our clients are made every day. When legislators see a strong and engaged membership base, they recognize that they are hearing from professionals who collectively serve thousands of consumers and employers throughout California.

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MEMBERSHIP MATTERS CONTINUED

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Your membership is more than an investment in your professional development; it is an investment in protecting the future of our industry and the consumers we serve. It ensures that when important healthcare decisions are being made, there is a knowledgeable voice at the table advocating for access, affordability, choice, and the continued value of professional guidance.

The reality is that advocacy only works when we stand together. Every member contributes to a stronger, more influential organization. Every membership helps amplify our voice. And every voice matters when it comes to protecting the role we play in helping consumers navigate healthcare.

The next time you renew your membership or encourage a colleague to join, remember that you are doing more than supporting an association you are helping ensure that our profession, our clients, and our communities continue to have representation where it matters most.

That is the power of membership. And that is why advocacy matters.

Melissa Calabretta, VP Membership



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Region 8 Gathering in San Francisco

Professional development through board service strengthens leadership, perspective, and impact.

Ailene Dewar Costello, Sarah Knapp, John Evangelista, John Roberts, and Lynn DeMaria attended the Region 8 gathering in San Francisco as part of their continued professional development within their board positions.



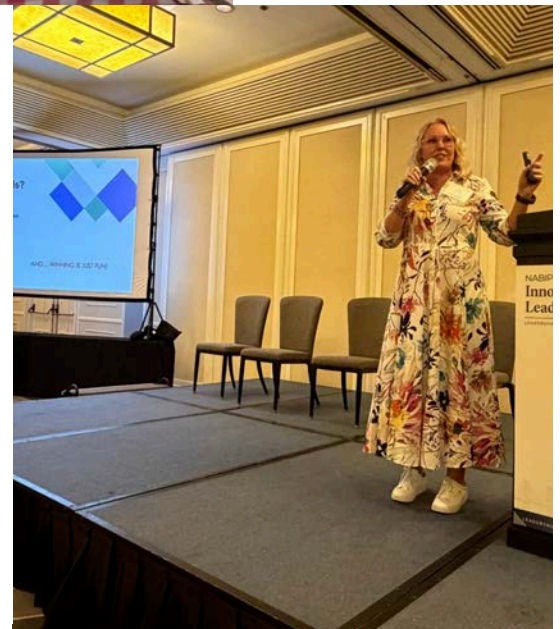
NABIP Professional Development



Are you new to the industry? Do you want to brush up on new concepts? Do you have employees who need training? Do you want to be an expert on industry topics so you can educate your clients? NABIP can help...

NABIP has an Online Learning Institute and offers courses in a variety of areas that can help you be successful. NABIP members receive a discount on enrollment of up to 30%. Some of the course work and certificates are listed below, but there are many more options on the website. For more information on courses and enrollment visit the NABIP Website at <https://nabip.org/professional-development>

- Registered Employee Benefits Consultants (REBC) Designation
- Single-Payer Healthcare Certification
- Account-Based Health Plans Certification
- Benefit Account Manager Certification
- Diversity, Equity and Inclusion in the Modern Workplace
- Self-Funded Certification
- HIPPA Compliance Training
- Leadership Academy



PREPARING CLIENTS FOR Q4

How Brokers and PEOs Can Help Employers Navigate Open Enrollment and Workforce Challenges

Insights for Licensed Agents and Advisors Heading into Open Enrollment Season

What's Keeping Employers Up at Night?

As we approach Q4, employers across the country are grappling with a familiar but intensifying set of challenges. Healthcare costs continue to rise, with many carriers projecting premium increases of 7-12% heading into the new plan year. At the same time, employers are navigating a volatile labor market, evolving compliance requirements, and growing pressure to offer competitive benefits packages that attract and retain top talent.

For brokers and PEOs, this environment presents both a challenge and an opportunity. Clients are looking for more than just plan options—they want strategic guidance, cost containment solutions, and a partner who understands the full picture of workforce management.

"Employers are overwhelmed," says Benjamin Codi, Divisional Vice President of Broker Sales. "They're not just asking which plan is cheapest anymore. They want to know how to keep their people healthy, productive, and engaged—without breaking the budget."

Why Open Enrollment Has Become More Complex

Open enrollment is no longer a simple annual exercise of selecting a health plan. Today's workforce spans multiple generations, each with different expectations around benefits. Gen Z employees may prioritize mental health resources and student loan assistance, while Baby Boomers are focused on retirement readiness and chronic condition management.

Additionally, the proliferation of plan types—HDHPs, ICHRAs, level-funded arrangements, and voluntary benefits—means employees face more choices than ever. Without proper education and decision-support tools, employees often default to the most expensive option or make selections that don't align with their actual healthcare needs.

Brokers who invest in employee education—through benefits fairs, one-on-one consultations, or digital enrollment platforms—are seeing higher satisfaction rates and better plan utilization among their clients' workforces.

"Employers are overwhelmed. They want to know how to keep their people healthy, productive, and engaged—without breaking the budget." — Benjamin Codi

The Broker's Role: From Quoting Plans to Strategic Advising

The role of the benefits broker has evolved significantly over the past decade. Where brokers once served primarily as intermediaries between carriers and employers, today's most successful brokers function as strategic consultants—helping clients navigate not just benefits selection, but total workforce strategy.

This shift requires brokers to stay current on regulatory changes, emerging benefit trends, and technology solutions that can streamline administration and improve the employee experience. It also means developing deeper relationships with clients, understanding their business goals, and proactively bringing solutions to the table rather than waiting for renewal season.

"The brokers who are thriving right now are the ones who show up in July and August, not just October," Codi notes. "They're having conversations about workforce planning, retention strategies, and compliance—not just quoting plans."

When Should Brokers Introduce a PEO Solution?

One of the most common questions brokers face is when to introduce a Professional Employer Organization (PEO) as a solution for their clients. The answer is: earlier than you might think.

PEOs are no longer a last resort for struggling small businesses. Today, PEOs serve companies ranging from 5 to 150+ employees, offering access to Fortune 500-level benefits, streamlined HR administration, workers' compensation solutions, and compliance support that would be cost-prohibitive for most employers to manage independently.

"Brokers sometimes hesitate to bring up PEOs because they're worried about losing the client," Codi explains. "But the reality is that a good PEO partnership actually strengthens the broker-client relationship. You become the person who solved a problem they didn't even know how to articulate."

The ideal time to introduce a PEO conversation is during Q3 planning—well before renewal pressure hits. This gives the employer time to evaluate options, ask questions, and make an informed decision without the stress of looming deadlines.

Workforce Trends Shaping 2027 Planning

Beyond benefits selection, brokers and PEOs must also help clients navigate broader workforce trends that are reshaping how companies attract, manage, and retain talent.

Recruitment and retention remain top concerns, particularly in industries like healthcare, manufacturing, and technology where talent shortages persist. Employers are increasingly looking to their benefits packages as a differentiator—offering flexible work arrangements, enhanced mental health support, financial wellness programs, and family-forming benefits to stand out in a competitive market.

Artificial intelligence is also beginning to reshape workforce planning. From AI-powered benefits administration platforms to predictive analytics that help employers identify flight risks and optimize compensation strategies, technology is becoming an essential tool in the HR toolkit.

“The employers who are going to win the talent war in 2027 are the ones investing in their people today,” Codi says. “That means competitive benefits, yes—but also career development, workplace flexibility, and a culture that prioritizes well-being.”

Building a Successful Broker-PEO Relationship

For brokers considering a PEO partnership, the key to success lies in finding the right fit—both for the client and for the broker’s practice. Not all PEOs are created equal, and the best partnerships are built on transparency, communication, and shared goals.

Brokers should look for PEO partners who respect the broker-client relationship, offer competitive commission structures, and provide robust support during implementation and beyond. The best PEOs view brokers as true partners—not competitors—and invest in tools and resources that help brokers grow their practice.

“A great PEO partnership should make the broker look like a hero,” Codi emphasizes. “When the client gets better benefits, streamlined HR, and compliance peace of mind—and the broker is the one who made it happen—everybody wins.”



Advice for Brokers Heading into Q4

As open enrollment season approaches, Codi offers several pieces of advice for brokers looking to strengthen their client relationships and grow their book of business:

Start early. Don't wait until renewal notices arrive to begin conversations with clients. The most successful brokers are already discussing strategy, benchmarking data, and exploring alternatives months before enrollment opens.

Diversify your solutions. Clients have different needs, and a one-size-fits-all approach no longer works. Be prepared to offer a range of options—from traditional fully-insured plans to level-funded arrangements, ICHRAs, and PEO solutions.

Invest in technology. Digital enrollment platforms, benefits decision-support tools, and data analytics can differentiate your practice and provide tangible value to clients.

Focus on education. Help clients understand not just what their options are, but why certain strategies make sense for their specific workforce demographics and business goals.

Build strategic partnerships. Whether it's with a PEO, a TPA, or a technology vendor, the right partnerships can expand your capabilities and allow you to serve clients more comprehensively.

Final Thoughts

The Q4 enrollment season represents a critical opportunity for brokers and PEOs to demonstrate their value and deepen client relationships. By approaching open enrollment as a strategic advising opportunity rather than a transactional exercise, brokers can position themselves as indispensable partners in their clients' success.

The employers who thrive in today's complex benefits landscape are the ones with trusted advisors by their side—professionals who understand the full picture of workforce management and can guide them through uncertainty with confidence and clarity.

Be that advisor. Your clients are counting on you.

Benjamin Codi

Divisional Vice President

Broker Sales, TriNet

benjamin.codi@TriNet.com

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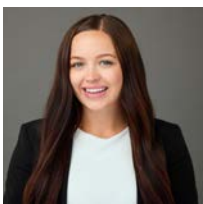
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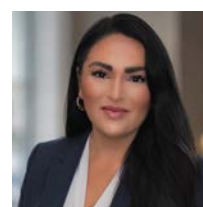
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Legislative Update

While many activities slow during the summer months, legislative advocacy remains active and ongoing. During the August congressional recess, CAHIP Orange County had the opportunity to engage locally with the offices of Congressmen Mike Levin, Lou Correa, and Derek Tran to discuss key issues affecting our industry. These meetings were made possible through the participation and support of our member volunteers.

We extend our sincere appreciation to Sarah Knapp, Lyn DeMaria, Maggie Stedt, Louis Valladares, Kelly Perkins, Bronson Lee, Ailene Dewar Costello, Dave Benson, and Luis Jaramillo for contributing their time and insights on important matters, including the role of the agent, cost-of-care transparency, preservation of employer tax incentives, and the Medicare Enrollment Protection Act. These issues were initially addressed during our February visit to Washington, D.C., and the local meetings provided a meaningful opportunity to continue and expand upon those discussions. We also extended an invitation to each Congressman, or an appropriate legislative staff member from their office, to attend a future monthly meeting, engage with our association, and gain a firsthand understanding of our work.

Legislative activity continues to advance rapidly at both the state and federal levels. As the midterm elections approach, it is especially important to know where to access reliable resources and remain informed on issues that may affect our industry and the clients we serve.

California – CAHIP CAHIP – Legislative Resources
Nationally – NABIP NABIP | Advocacy

Where does NABIP stand on key issues:

SINGLE PAYER

NABIP strongly opposes all forms of single-payer healthcare and is committed to promoting employer-sponsored health coverage and preserve Medicare, Medicaid, and other existing health programs.

EMPLOYER EXCLUSION

NABIP opposes any efforts that would eliminate or cap the employer-tax exclusion for health insurance.

EMPLOYER REPORTING

NABIP supports legislation to streamline the employer reporting process and strengthen the eligibility verification process for the health care premium tax credit and cost-sharing subsidy.

COBRA COVERAGE

NABIP supports legislation to allow seniors enrolled in COBRA coverage to transition to Medicare Part B without a penalty, the same as seniors who remain on similar employer-sponsored coverage, by providing for a one-time special enrollment period.



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OBSERVATION STATUS

NABIP supports legislation to allow observation stays to be counted toward the three-day mandatory inpatient stay for Medicare coverage of a skilled nursing facility.

HSA REFORMS

NABIP supports legislation to address issues with HSAs and employer-sponsored coverage and modernize HSA regulations.

FULL-TIME STATUS

NABIP supports legislation to repeal the 30-hour threshold for full-time employee for purposes of the employer mandate in the PPACA and replace it with 40 hours.

MEDICAL LOSS RATIO

NABIP supports legislation to remove the agent/broker compensation from the Medical Loss Ratio (MLR) Requirement in the individual and small group markets.



Tracy Hanson | VP Legislation | Tracy.Hanson@blueshieldca.com | (714) 319-1379



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Member Spotlights

Published in CA Broker Magazine

Ailene Dewar Costello

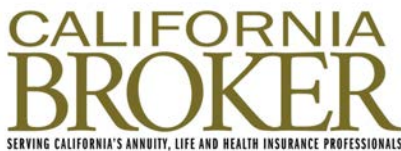
Ailene Dewar Costello is featured in California Broker Magazine with her article, 'Handling Difficult Conversations: Helping Clients Balance Leadership Communication and Compliance.'

Published in CA Broker Magazine

Sarah Knapp

Sarah Knapp is featured in California Broker Magazine, sharing why education around benefit enrollment matters—and why getting involved with advocacy helps strengthen the voice of health insurance professionals.

Education, enrollment, and advocacy



Scan to read
the articles



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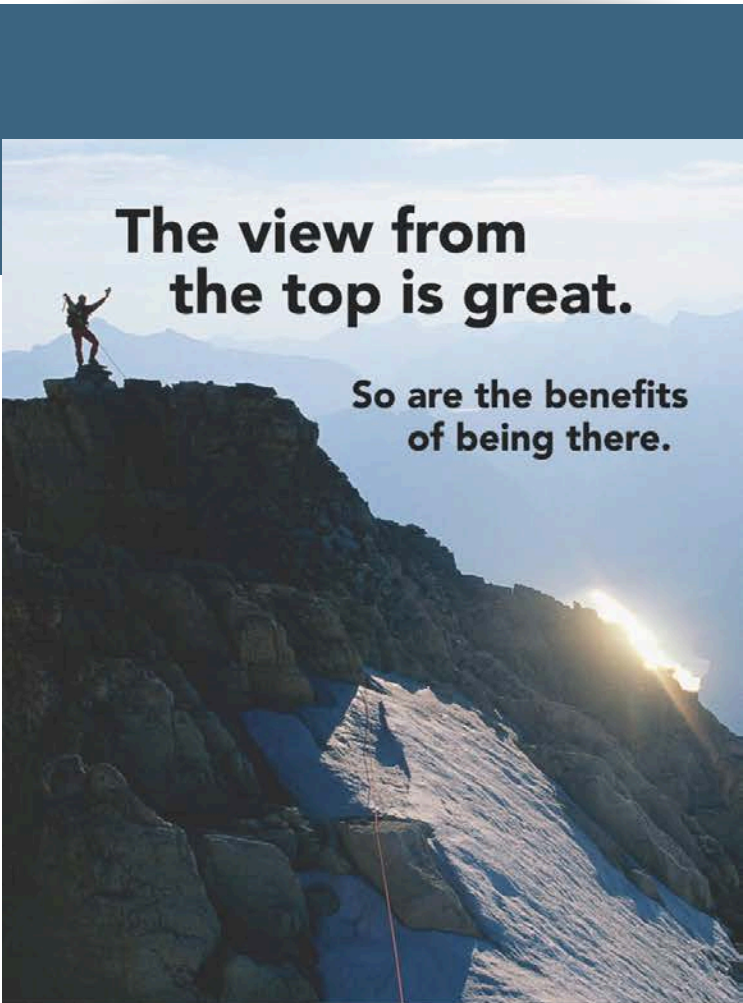
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